STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
CORDELL HULL BUILDING, FIRST FLOOR
425 FIFTH AVENUE NORTH
NASHVILLE, TN 37247-0701
TELEPHONE: 615-741-2584 FAX# 615-741-4217

RECIPROCITY REQUIREMENTS FOR EMS PERSONNEL LICENSE

This packet contains the information needed for EMS personnel who have a current license or certification from other states and are seeking licensure in Tennessee, or have completed their training from a Non Accredited Tennessee Training Institution and are seeking initial licensure in Tennessee

In order for a license to be issued you must:

* Submit all of the required documentation on the attached list.
* Pay **all** required fees.
* Complete **any additional training** which may be required.
* Successfully pass **any examinations** that may be required.

Your application package will be reviewed upon receipt of written verification from the issuing EMS licensing agency of your current EMS Certification/License or upon receipt of written verification of training from your training institution. The Division of Emergency Medical Services does not issue temporary licenses for employment.

ALL THE REQUIRED DOCUMENTATION AND FEES MUST BE SUBMITTED IN ONE PACKAGE. THE ONLY EXCEPT IS THE "**VERIFICATION OF EMS CERTIFICATION/ LICENSURE FORM**" or "**VERIFICAITON OF TRAINING PACKET",** WHICH MUST BE MAILED TO THE STATE WHERE YOU HOLD CURRENT CERTIFICATION/LICENSE OR TO THE TRAINING INSTITUTION IN WHICH YOUR TRAINING WAS COMPLETED. ANY INCOMPLETE APPLICATION PACKAGE WILL BE RETURNED.

Submit all documentation to:

Tennessee Department of Health
Division of Emergency Medical Services
Personnel Licensure - Reciprocity
Cordell Hull Building, First Floor
425 Fifth Avenue, North
Nashville, TN 37247-0701

THE APPLICATION PROCESS

With your cooperation, we will make every effort to expedite your application.

PLEASE READ

1. **WE DO NOT ACCEPT OR SEND FAXES TO EXPEDITE YOUR APPLICATION.** Allow 14 working days for information mailed to our office to be received and placed in your file. Federal Special courier services will not appreciably reduce the process time. If you wish verification that the Division has received your application packet, it is recommended that you mail the packet certified mail. If special services are used, you are responsible for incurred charges. **Special courier services must be sent to:**

   TENNESSEE DEPARTMENT OF HEALTH
   DIVISION OF EMERGENCY MEDICAL SERVICES
   EMS PERSONNEL LICENSURE - RECIPROCITY
   CORDELL HULL BUILDING, FIRST FLOOR
   425 FIFTH AVENUE, NORTH
   NASHVILLE, TN 37247-0701

2. Absent any complicating factors, the average application processing time is ***30 days*** from receipt of all the documentation**.**

3. **We will discuss application status with the APPLICANT only**. Please inform potential employers and any others that application status updates must be obtained from you.

4. Examinations dates for National Registry testing can be acquired from the NREMT web site (www.nremt.org) or by calling the Registry at 614-888-4484. You may also contact the EMS Regional Consultant (listing provided in this packet) to obtain dates for open exams scheduled in Tennessee. All **examination results will be provided by mail only.** Examination scores or if you "passed" or "failed" will not be given verbally.

5. If an address change occurs at any time during the application process, you must notify this agency in writing.

6. **Anyone practicing as an EMT-IV or Paramedic must hold a valid license from the State of Tennessee, Department of Health**. Therefore, it is recommended that you do not make arrangements to accept employment in Tennessee until you are granted a license by this agency.

READ: ***"IMPORTANT"***

RECENT CHANGE IN THE ENTRY LEVEL TO PRACTICE IN TENNESSEE

ALL EMT BASICS MUST HAVE INTRAVENOUS THERAPY (EMT-IV)

TENNESSEE NO LONGER ACCEPTS EMT BASIC AS THE ENTRY LEVEL TO PRACTICE IN TENNESSEE

ATTENTION: EMT-IV'S
REFERENCE: ADDITIONAL TRAINING

THE STATE OF TENNESSEE REQUIRES THAT ANY PERSON APPLYING FOR LICENSURE AS AN EMT-IV COMPLETE THE 1994 NATIONAL DEPARTMENT OF TRANSPORTATION CURRICULUM OR AN APPROVED TRANSISTIONAL/BRIDGE COURSE AND HAVE COMPLETED INTRAVENOUS THERAPY BEFORE A LICENSE CAN BE ISSUED. TO RECEIVE RECIPROCITY **YOU MUST PROVIDE PROOF OF SUCCESSFUL COMPLETION OF THE 1994 CURRICULUM OR PROOF OF COMPLETION OF A TRANSITIONAL/BRIDGE COURSE AND INTRAVENOUS THERAPY.** AGAIN THIS MUST BE COMPLETED PRIOR TO SUBMITTING THE RECIPROCITY APPLICATION. THIS PACKET PROVIDES A LISTING OF EDUCATIONAL INSTITUTIONS THAT MAY BE CONTACTED FOR INFORMATION CONCERNING THE REQUIRED TRAINING.

ATTENTION: EMT-PARAMEDICS
REFERENCE: ADDITIONAL TRAINING

THE STATE OF TENNESSEE REQUIRES THAT ANY PERSON APPLYING FOR LICENSURE AS AN EMT-PARAMEDIC COMPLETE THE 1999 NATIONAL DEPARTMENT OF TRANSPORTATION CURRICULUM OR AN APPROVED TRANSISTIONAL/BRIDGE COURSE BEFORE A LICENSE CAN BE ISSUED. TO RECEIVE RECIPROCITY **YOU MUST PROVIDE PROOF OF SUCCESSFUL COMPLETION OF THE 1999 CURRICULUM OR COMPLETE THE TRANSITIONAL/BRIDGE COURSE.** AGAIN THIS MUST BE COMPLETED PRIOR TO SUBMITTING THE RECIPROCITY APPLICATION. THIS PACKET PROVIDES A LISTING OF EDUCATIONAL INSTITUTIONS THAT MAY BE CONTACTED FOR INFORMATION CONCERNING THE REQUIRED TRAINING.

IF YOU HOLD A LICENSE IN ANOTHER STATE MARK ***RECIPROITY*** ON THE APPLICATION PACKET.

IF YOU **DO NOT** HOLD A LICENSE IN ANOTHER STATE AND ARE SEEKING LICENSE MARK ***INITIAL*** ON THE APPLICATION IN THE PACKET.

IF YOU ARE APPLYING FOR RECIPROCITY **(and you hold a license in another state)** THE FOLLOWING PAGES MUST BE RETURNED AS ONE PACKET, ***except*** **the Verification of Current EMS Certification/Licensure Form**. This form should be mailed to the state verifying your current license/certification status.

OR

IF YOU COMPLETED YOUR TRAINING FROM A NON ACCREDITED TENNESSEE TRAINING INSTITUTION ***WITHIN THE LAST SIX MONTHS*** AND DO NOT HOLD A LICENSE IN ANOTHER STATE YOU MUST RETURN THE FOLLOWING PAGES AS ONE PACKET ***EXCEPT*** **the Training Documentation Packet. The Training Document Packet should be sent to the training institution in which you received your training to be completed and returned to this office by the training institution**.
The Verification of Current EMS Certification/Licensure Form **is not applicable for those who do not have a license in another state**.

PLEASE CHOOSE APPROPRIATE CHECKLIST FOR YOUR APPLICATION PROCESS.

- **Certified or Licensed in another state**
  Or
- **Initial License**

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
CORDELL BUILDING, FIRST FLOOR
425 FIFTH AVENUE, NORTH
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RECIPROCITY CHECKLIST
(Certified or Licensed in Another State)

The following general requirements must be met by all Emergency Medical Technicians **and** Paramedics. The following must be submitted:

General Requirements:

1.☐ **Proof of High School Education:**
A copy of high school Diploma or a Graduate Equivalency Diploma (GED Certificate). A college transcript or degree may be submitted.

2.☐ **Proof of Current CPR Training:**
A copy of your current CPR card from the American Heart Association or American Red Cross, which signifies training in CPR for the Professional Rescuer or Healthcare Provider.

3.☐ **Application for Licensure:**
Answer all questions and sign.
The business name refers to employment with an Emergency Medical Service or similar organization approved to operate in the State of Tennessee. If not employed, indicate Not Applicable.
EMT-IV = Intermediate Level
Application must be signed and dated before processing will begin. The signed application is valid for one year from the date of your signature.

4.☐ **Medical Statement for EMS Personnel (PH-0130):**
Complete the form so that the physician's name and address can be verified. The physical exam is valid if completed in the past six months, but information must be explained on the form provided in this packet.

5.☐ **Current State Certification/License:**
Submit a copy of your existing licensure/certification should be valid for at least 3 months after you apply. Mail the EMS licensure/certification verification form to all states which you hold or have held a license/certification to include your initial license/certification state.

6.☐ **National Registry Certification:**
You must have currently hold or have held a National Registry certification at the level which you are applying.

7.☐ **Knowledge of Destination Determinations:**
All applicants must read the trauma destination guidelines. These are included in the packet and must be verified by signing the appropriate sheet.

8.☐ **Fees:**
Submit the fee form (PH-2397) with a check or money order for all appropriate fees. If you would like confirmation of receipt of your fee, please mail certified mail receipt requested**.**
NOTE: Fees Are Subject To Change Without Notice.

Additional Requirements:

You must meet the general requirements and also provide the following according to level of license applying:

Paramedics

1. ☐ Must show Verification of Training on the most current National DOT Curriculum for EMT Paramedic or Verification of additional training to meet current DOT curriculum.

Is all documentation included in your return packet?

REMEMBER: ALL REQUIRED DOCUMENTATION, FORMS, AND FEES MUST BE SUBMITTED TOGETHER AS ONE PACKET. (Excluding Packet from State verifying licensure and education) IF YOUR APPLICATION PACKET IS INCOMPLETE, IT WILL BE RETURNED TO YOU.

Questions

Contact Central Office
Donna Tidwell
Director of EMS Personnel Licensure and Education
donna.g.tidwell@state.tn.us
Phone: 615-741-2584

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
CORDELL BUILDING, FIRST FLOOR
425 FIFTH AVENUE, NORTH
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RECIPROCITY CHECKLIST
(Initial License)

The following general requirements must be met by all Emergency Medical Technician IVs **and** Paramedics. The following must be submitted:

General Requirements:

1.☐ **Proof of High School Education:**
A copy of high school Diploma or a Graduate Equivalency Diploma (GED Certificate). A college transcript or degree may be submitted.

2.☐ **Proof of Current CPR Training:**
A copy of your current CPR card from the American Heart Association or American Red Cross, which signifies training in CPR for the Professional Rescuer or Healthcare Provider.

3.☐ **Application for Licensure:**
Answer all questions and sign.
The business name refers to employment with an Emergency Medical Service or similar organization approved to operate in the State of Tennessee. If not employed, indicate Not Applicable.
EMT-IV = Intermediate Level
Application must be signed and dated before processing will begin. The signed application is valid for one year from the date of your signature.

4.☐ **Medical Statement for EMS Personnel (PH-0130):**
Complete the form so that the physician's name and address can be verified. The physical exam is valid if completed in the past six months, but information must be explained on the form provided in this packet.

5.☐ **National Registry Certification:**
You must have currently hold or have held a National Registry certification at the level which you are applying.

6.☐ **Knowledge of Destination Determinations:**
All applicants must read the trauma destination guidelines. These are included in the packet and must be verified by signing the appropriate sheet.

7.☐ **Fees**:
Submit the fee form (PH-2397) with a check or money order for all appropriate fees. If you would like confirmation of receipt of your fee, please mail certified mail receipt requested**.**
NOTE: Fees Are Subject To Change Without Notice.

Additional Requirements:

You must meet the general requirements and also provide the following according to level of license applying:

A. ☐ **Paramedics:** Completed Training Packet submitted from Training Institution to the EMS Division to include the following.

1. ☐ Verification of Training on the most current National DOT Curriculum for EMT Paramedic or Verification of additional training to meet current DOT curriculum.
2. ☐ Verification of Paramedic Comprehensive Skills in competency and/or theory.

Is all documentation included in your return packet?

REMEMBER: ALL REQUIRED DOCUMENTATION, FORMS, AND FEES MUST BE SUBMITTED TOGETHER AS ONE PACKET. (Excluding Packet from State verifying licensure and education) IF YOUR APPLICATION PACKET IS INCOMPLETE, IT WILL BE RETURNED TO YOU.

Questions
Contact Central Office
Donna Tidwell
Director of EMS Personnel Licensure and Education
donna.g.tidwell@state.tn.us
Phone: 615-741-2584

Office Use Only Application Code
_____

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATIONS
DIVISION OF EMERGENCY MEDICAL SERVICES
CORDELL HULL BUILDING, FIRST FLOOR
425 FIFTH AVENUE NORTH
NASHVILLE, TENNESSEE 37247-0701

EMS RECIPROCITY APPLICATION

☐ **RECIPROCITY (holds a license in another state)** ☐ **INITIAL (Training from a NON Accredited TN EMS Training Institution)**

SSN: _____ **NAME:** _____
LAST FIRST MIDDLE (JR., II, III)

MAILING ADDRESS: _____
STREET ADDRESS

_____
CITY COUNTY STATE ZIP

TELEPHONE: (_____) _____ **BIRTHDAY:** _____/_____/_____
MONTH / DAY / YEAR

RACE: ☐ WHITE ☐ BLACK ☐ NATIVE ☐ ASIAN ☐ HISPANIC ☐ OTHER

SEX: ☐ MALE ☐ FEMALE

ARE YOU CURRENTLY WORKING IN EMS? ☐ FULL TIME ☐ PART TIME ☐ NOT APPLICABLE

IF YOU ARE WORKING IN EMS PLEASE MARK THE MOST APPROPRIATE SELECTION:

☐ AMBULANCE SERVICE	☐ INDUSTRY	☐ RESCUE SQUAD
☐ FIRE DEPARTMENT	☐ HOSPITAL	☐ DISPATCH CENTER
☐ OTHER	☐ N/A	

RANK OF LICENSURE REQUESTING: ☐ EMD ☐ EMT - IV ☐ PARAMEDIC

ARE YOU CURRENTLY OR HAVE YOU EVER BEEN CERTIFIED WITH THE NATIONAL REGISTRY?
☐ YES ☐ NO

ARE YOU CURRENTLY OR HAVE YOU EVER BEEN LICENSED/CERTIFIED IN ANOTHER STATE?
☐ YES ☐ NO

IF YES, LIST BELOW

STATE: _____ LEVEL: _____ LIC/CERT NUMBER: _____ EXPIRATION DATE: _____

STATE: _____ LEVEL: _____ LIC/CERT NUMBER: _____ EXPIRATION DATE: _____

SIGNATURE _____ **DATE** _____

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
425 FIFTH AVENUE, NORTH
CORDELL BUILDING, FIRST FLOOR
NASHVILLE, TENNESSEE 37247-0701

MEDICAL STATEMENT
For Emergency Medical Services Professional License

The Division of Emergency Medical Services is the state agency responsible for the licensing of emergency medical services personnel. The mission of the agency is to oversee the delivery of pre-hospital emergency care and to safeguard the public from inappropriate or incompetent medical care in the pre-hospital environment. When issuing a license, it is understood that the individual can meet the demands, duties, and responsibilities listed below.

GENERAL DUTY REQUIREMENTS:

The general environmental conditions in which emergency medical service personnel work includes a variety of hot and cold temperatures and, at times, they may be exposed to hazardous fumes. They may be required to walk, climb, crawl, bend, pull, push, or lift and balance over less than ideal terrain. They can also be exposed to a variety of noise levels, which can be quite high, particularly when sirens are sounding. The individual must be able to function effectively in uncontrolled environments with high levels of ambient noise. Aptitudes required for work of this nature are good physical stamina, endurance, and body condition which would not be adversely affected by having times to lift, move, carry and balance while moving in excess of 125 pounds (250 pounds 2 person lift). Motor Coordination is dexterity to bandage, splint and move patients, including properly applying invasive airways and administering injections.

Driving in a safe manner, accurately discerning street names, map reading, and the ability to correctly distinguish house numbers or business locations are essential tasks. Use of the telephone or radio for transmitting and responding to physician's advice is also essential. The ability to concisely and accurately describe orally to health professionals the patient's condition is critical. The provider must also be able to accurately summarize all data in the form of a written report.

_____

TYPE APPLICANTS NAME

HAS BEEN EXAMINED AND DEMONSTRATES SUFFICIENT HEALTH TO PERFORM THE ESSENTIAL FUNCTIONS IN THE PRE-HOSPITAL ENVIRONMENT AS DESCRIBED IN THE GENERAL DUTY REQUIREMENTS ABOVE INCLUDING VISUAL ACUITY, SPEECH, HEARING, AND THE USE OF EXTREMITIES.

_____	_____	_____
PRINT PROVIDER'S NAME	**PROVIDER'S LICENSE NUMBER**	**STATE**
_____	_____	
PROVIDER'S SIGNATURE	**DATE**	

AUTHORIZATION FOR RELEASE OF INFORMATION:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION BY THE EXAMINER NECESSARY FOR QUALIFICATION TO MY EMPLOYER FOR DETERMINATION OF MY ELIGIBILITY BY THE DIVISION OF EMERGENCY MEDICAL SERVICES.

_____	_____	_____
SIGNATURE OF APPLICANT	**SOCIAL SECURITY NUMBER**	**DATE**

"Under HIPPA, the health information you furnish on this document is protected from public inspection, absent a subpoena or for purposes of health oversight activities."

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
425 FIFTH AVENUE, NORTH
CORDELL BUILDING, FIRST FLOOR
NASHVILLE, TENNESSEE 37247-0701

EMS CERTIFICATION/LICENSE VERIFICATION

Complete the **TOP** portion of this form and mail to the State you received your current certification/licensure. Reproduce this form if certification/licensure is held in more than one state.

ATTENTION: _____ EMS Personnel Certification/Licensure Section
(STATE)

I am applying for an EMS license in the State of Tennessee and authorize your agency to release the information requested in the lower section of this form. Please mail the completed form to the Tennessee Division of Emergency Medical Services.

NAME: _____
Last First Middle

ADDRESS: _____
Street City State Zip

DOB:_____ **SSN**:_____ **CERTIFICATION/LICENSE #** _____

Certification/Licensure Level Applying For: ☐ **EMD** ☐ **EMT** ☐ **EMT-I** ☐ **PARAMEDIC**

SIGNATURE:_____ **DATE**:_____

THIS SECTION TO BE COMPLETED BY CERTIFYING AGENCY

Did the individual identified above successfully complete an approved current National Department of Transportation Curriculum for the level in which they are licensed in your state?

☐ **Yes** ☐ **No** **Date Training Completed:** _____ **Total Hours:**_____

If the above answer was no did this individual successfully complete an approved EMT Basic transitional course?

☐ **Yes** ☐ **No** **Date Training Completed:** _____ **Total Hours**_____

Certification/Licensure Level:

☐ **EMD** ☐ **EMT** ☐ **EMT-I** ☐ **PARAMEDIC** ☐ **OTHER**_____
(Type)

Did the training or additional endorsement include?

☐ **Mast**	☐ **AED**	☐ **Epinephrine**	☐ **IV Administration**
☐ **IV Maintenance**	☐ **EOA**	☐ **Combi-tube Airway**	☐ **PtL Airway**
☐ **Tracheal Intubation**	☐ **NTG**	☐ **Inhalers**	☐ **D50 Administration**

Did this individual reciprocate from another state? ☐ **Yes** ☐ **No**

State: _____ **Date:** _____

Is this certification/licensure current and valid in your state? ☐ **Yes** ☐ **No**

Certification/License Number: _____ **Expiration Date:** _____

Was initial written exam score above 70%? ☐ **Yes** ☐ **No**

Was a successful practical examination required? ☐ **Yes** ☐ **No**

Has this individual's license ever been restricted, suspended or revoked as a result of disciplinary action?
☐ **Yes** ☐ **No**

If yes, Please explain: _____

_____

Do you know of any reason why this individual should be denied an EMT certification/license?
☐ **Yes** ☐ **No**

If yes, please explain: _____

_____

I certify that the information provided is true and correct.

Agency Name: _____

Signature of Agency Representative: _____

Print Name of Agency Representative: _____

Date: _____ **Telephone:** _____

Board or State Seal

Your cooperation is greatly appreciated. If you have questions, please contact the training section at (615) 741-4521. Please return this form the address at the top of the first page.

THE FOLLOWING AND SIGN AND RETURN THE ENCLOSED VERIFICAITON OF SUCH WITH YOUR APPLICATION PACKET.

1200-12-1-.21 Destination Determination – Sick or injured persons who are in need of transport to a health care facility by a ground or air ambulance requiring licensure by the State of Tennessee should be transported according to these destination rules.

(1) Trauma patients - The goal of the pre-hospital component of the trauma system and destination guidelines is to minimize injury through safe and rapid transport of the injured patient. The patient should be taken directly to the center most appropriately equipped and staffed to handle the patient's injury as defined by the region's trauma system. These destinations should be clearly identified and understood by regional prehospital personnel and should be determined by triage protocols or by direct medical direction. Ambulances should bypass those facilities not identified by the region's trauma system as appropriate destinations, even if they are closest to the incident.

(2) Beginning no later than six (6) months after the designation of a trauma center in any region, persons in that region, who are in need of transport who have been involved in a traumatic incident and who are suffering from trauma or a traumatic injury as a result thereof as determined by triage at the scene, should be transported according to the following rules.

(a) Adult (greater than or equal to fifteen (15) years of age) and Pediatric (less than fifteen (15) years of age) Trauma Patients will be triaged and transported according to the flow chart labeled "Field Triage Decision Scheme" in "Resources For Optimal Care of the Injured Patient: 1999," or any successor publication. The Pediatric Trauma Score shall be used as published in "Basic Trauma Life Support for Paramedics and Other Advanced EMS Providers," Fourth Edition, 2000. Copies of the charts are available from the Division.

1. Step One and Step Two patients should go to a Level 1 Trauma Center or Comprehensive Regional Pediatric Center (CRPC), either initially or after stabilization at another facility. EMS field personnel may initiate air ambulance response.

2. Step One or Step Two pediatric patients should be transported to a Comprehensive Regional Pediatric Center (CRPC) or to an adult Level 1 Trauma Center if no CRPC is available. Local Destination Guidelines should assure that in regions with two CRPC's or one CRPC and another facility with Level 1 Adult Trauma capability, that seriously injured children are cared for in the facility most appropriate for their injuries.

3. For pediatric patients, a Pediatric Trauma Score of less than equal to 8 ($\leq$8) will be considered as a cutoff level for Step One patients.

4. Local or Regional Trauma Medical Control may establish criteria to allow for non-transport of clearly uninjured patients.

5. Trauma Medical Control will determine patient destinations within thirty (30) minutes by ground transport of a Level 1 Trauma Center or CRPC.

(b) Exceptions apply in the following circumstances:

1. For ground ambulances, when transport to a Level I Trauma Center will exceed thirty (30) minutes, Trauma Medical Control will determine the patient's destination. If Trauma Medical Control is not available, the patient should be transported to the closest appropriate medical facility.

2. For air ambulances, Step One patients will be transported to the most rapidly accessible Level I Trauma Center, taking safety and operational issues into consideration. Step Two, Three, and Four patients will be transported to a Level I Trauma Center as determined by the air ambulance's Medical Control. The

Flight Crew will make determination of patient status on arrival of the air ambulance.

3. Air ambulances will not transport chemical or radiation contaminated patients prior to decontamination.

4. If the Trauma Center chosen as the patient's destination is overloaded and cannot treat the patient, Trauma Medical Control shall determine the patient's destination. If Trauma or Medical Control is not available, the patient's destination shall be determined pursuant to regional or local destination guidelines.

5. A transport may be diverted from the original destination:

(1) if a patient's condition becomes unmanageable or exceeds the capabilities of the transporting unit; or
(2) if Trauma Medical Control deems that transport to a Level I Trauma Center is not necessary.

(c) Utilization of any of the exceptions listed above should prompt review of that transport by the quality improvement process and the medical director of the individual EMS providers.

(d) Trauma Medical Control can be accomplished by a Trauma or Emergency Physician on duty at a designated Trauma Center or by protocols established in conjunction with a Regional Level I Trauma Center.

(3) Pediatric Medical Emergency - Pediatric patients represent a unique patient population with special care requirements in illness and injury. Tennessee has a comprehensive destination system for emergency care facilities in regards to pediatric patients where there are variable levels of available care, as defined in Rule 1200-9-30-.01.

(a) There are circumstances in pediatric emergency care as determined by local medical control where it would be appropriate to bypass a basic or a primary care facility for a general or comprehensive regional pediatric center.

(i) Examples of such circumstances include, but are not limited to the following

(I) On-going seizures
(II) A poorly responsive infant or lethargic child
(III) Cardiac arrest
(IV) Significant toxic ingestion history
(V) Progressive respiratory distress (cyanosis)
(VI) Massive gastrointestinal (GI) bleed
(VII) Life threatening dysrhythmias
(VIII) Compromised airway
(IX) Signs or symptoms of shock
(X) Severe respiratory distress
(XI) Respiratory arrest
(X) Febrile infant less than two months of age.

(ii) Pediatric medical emergency transport may be diverted from the original destination if the patient's condition becomes unmanageable or exceeds the capability of the transporting unit, in which case the patient should be treated at the closest facility.

(iii) Pediatric medical emergency air ambulance transports must go to a Comprehensive Regional Pediatric Center.

(b) Pediatric trauma patients should be taken to trauma facilities as provided in paragraph (2).

(4) Any patient who does not qualify for transport to a Trauma Center or a Comprehensive Regional Pediatric Center should be transported to the most appropriate facility in accordance with regional or local destination guidelines.

(5) Adults or children with specialized healthcare needs beyond those already addressed should have their destination determined by Medical or Trauma Control, by regional or local guidelines, or by previous arrangement on the part of patient (or his/her family or physician).

(6) A transport may be refused or an alternate destination requested. Non-transport of the patient, or transport of the patient to an alternate destination shall not violate this rule and shall not constitute refusal of care

Authority: *T.C.A. §§ 4-5-202, 68-140-504, 68-140-505, 68-140-509, and 68-140-521.* ***Administrative History****: Original rule filed October 15, 2002; effective December 29, 2002.*

Paragraph (7) of Rule 1200-12-1-.11 Ambulance Service Operations and Procedures is repealed.

Authority: T.C.A. §§ 4-5-202, 68-140-504, 68-140-505, 68-140-509, and 68-140-521.

FIELD TRIAGE DECISION SCHEME

Measure vital signs and level of consciousness

Step One[1]

- Glasgow Coma Scale ..... <15 or [2]
- Systolic blood pressure ..... < 90 or
- Respiratory rate ..... <10 or >29
- Revised Trauma Score (see Table 2) ..... <11

YES / NO

Step Two[3]

- All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee
- Flail chest
- Combination trauma with burns
- Two or more proximal long-bone fractures
- Pelvic fractures
- Open and depressed skull fracture
- Paralysis
- Amputation proximal to wrist and ankle
- Major burns (see Chapter 14: Guidelines for the Operation of Burn Units)

YES / NO

Take to trauma center; alert trauma team

Steps 1 and 2 triage attempts identify the most seriously injured patients in the field. In a trauma system, these patients would preferentially be transported to the highest level of care within the system.

Evaluate for evidence of mechanism of injury and high-energy impact

Step Three[4]

- Ejection from automobile
- Death in same passenger compartment
- Extrication time >20 minutes
- Falls >20 feet
- Rollover
- High-speed auto crash
  - Initial speed >40 mph
  - Major auto deformity >20 inches
  - Intrusion into passenger compartment >12 inches
- Auto-pedestrian/auto-bicycle injury with significant (>5 mph) impact
- Pedestrian thrown or run over
- Motorcycle crash >20 mph or with separation of rider from bike

YES / NO

Contact medical direction and consider transport to a trauma center

Consider trauma team alert

Step Four[5]

- Age <5 or >55
- Cardiac disease, respiratory disease
- Insulin-dependent diabetes, cirrhosis, or morbid obesity
- Pregnancy
- Immunosuppressed patients
- Patient with bleeding disorder or patient on anticoagulants

YES / NO

Contact medical direction and consider transport to trauma center

Consider trauma team alert

Reevaluate with medical direction

WHEN IN DOUBT TAKE TO A TRAUMA CENTER

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
CORDELL HULL BUILDING, FIRST FLOOR
425 FIFTH AVENUE, NORTH
NASHVILLE, TN 37247-0701

RECIPROCITY SKILLS CHECKLIST

SECTION I: **DESTINATION GUIDELINES**

ALL APPLICANTS: **(MUST READ AND SIGN SECTION I)**

I have read and understand the rules regarding destination guidelines for trauma patients.

Print Applicant Name | Applicant Signature | Social Security Number

SECTION II: **EMT EXTENDED SKILLS CURRICULUM**

This section is to verify that the above named individual has demonstrated proficiency to the Tennessee approved curriculum for EMT EXTENDED SKILLS. This program was verified by the undersigned and meets the guidelines of the Tennessee Division of Emergency Medical Services.

Print TN I/C Name | TN I/C Signature | Location & Date of Training

IF YOU COMPLETED A STATE PRACTICAL EXAMINATION FOR IV CERTIFICATION PLEASE PROVIDE THE FOLLOWING INFORMATION:

Date of Examination:_____ Location:_____

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATIONS
DIVISION OF EMERGENCY MEDICAL SERVICES
CORDELL HULL BUILDING, FIRST FLOOR
425 FIFTH AVENUE NORTH
NASHVILLE, TENNESSEE 37247-0701

OFFICE USE ONLY	
707 - 1st Responder	_____
718 - EMT, IV, PM	_____
719 – EMD	_____

EMS PROFESSIONAL FEES

Class Number: (If Applicable) _____ **SSN:** _____

Name: _____
Last First Middle (Jr., Sr., etc.)

Address: _____ **Birthday:** ____/____/____

_____ **Phone: (____)** _____
City State Zip

EMS Employer: _____ **Phone: (____)** _____

Have you ever been convicted, for a violation of the law other than a minor traffic violation **Yes** _____ **No** _____

Have you ever or are you now addicted to any alcohol or drugs? **Yes** _____ **No** _____

Has your license/certification to practice in any state ever been reprimanded, suspended, restricted, revoked or is it under threat of disciplinary action? **Yes** _____ **No** _____

If you answered yes to either question, give details on a separate sheet including circumstances with appropriate dates. Attach a certified copy of court records if convicted of any law violation.

I certify that all information in this form is correct and complete to the best of my knowledge. I understand that falsification of any information may be grounds for denial or revocation of my certification/license.

Signature: _____ **Date:** _____

This application must be signed and dated to insure processing.

Please **check the appropriate box(es)** and submit this form with the total fee(s) by a personal or certified check (**no cash**). Payment should be made payable to **TDH-EMS. This form must be submitted fifteen (15) days prior to your examination date**. Failure to comply with these instructions will result in a delay of your license approval.

ACTION	EMT-B (718)	EMT-IV (718)	PARAMEDIC (718)	FIRST RESPONDER (707)	EMD (719)
Application Fee	☐ $50.00	☐ $70.00	☐ $75.00	☐ $20.00	☐ $30.00
License Fee	☐ $75.00	☐ $80.00	☐ $100.00	☐ $25.00	☐ $30.00
Renewal Fee	☐ $48.00	☐ $48.00	☐ $48.00	☐ $24.00	☐ $30.00
Reinstatement Fee	☐ $25.00	☐ $25.00	☐ $25.00	☐ $25.00	☐ $25.00
Renewal Test Fee	☐ $100.00	☐ $100.00	☐ $100.00		
Reciprocity Fee	☐ $100.00	☐ $100.00	☐ $100.00		

TOTAL FEE = _____

"Under HIPPA, the health information you furnish on this document is protected from public inspection, absent a subpoena or for purposes of health oversight activities."

THIS PORTION OF THE PACKET IS ONLY COMPLETED IF YOU DO NOT HOLD A LICENSE OR CERTIFICATION IN ANOTHER STATE.

THE FOLLOWING TRAINING PACKET MUST BE COMPLETED BY THE TRAINING INSTITUTION FROM WHICH YOU RECEIVED YOUR TRAINING. CHECK THE PACKET AND SIGN ALL FORMS REQUIRING A STUDENT SIGNATURE BEFORE MAILING TO THE TRAINING INSTITUTION.

THE TRAINING INSTITUTION MUST RETURN THE DOCUMENTATION TO:

Tennessee Department of Health
Division of Emergency Medical Services
Personnel Licensure – Non TN Accredited Training
Cordell Hull Building, First Floor
425 Fifth Avenue, North
Nashville, TN 37247-0701

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
CORDELL HULL BUILDING, FIRST FLOOR
425 FIFTH AVENUE NORTH
NASHVILLE, TN 37247-0701
PHONE: 615-741-2584
FAX: 615-741-4217

VERIFICATION OF COURSE AND ATTENDANCE

Name:_____ **Social Security Number:**_____

Please indicate the level of Training you are verifying for the above individual:

☐ **EMT Basic** ☐ **EMT Intermediate** ☐ **Paramedic**

Training Institution: _____

Address:_____
Street City State Zip

Course Instructor:_____

Course Location:_____ **Course Date**:_____

Please indicate which version of the Curriculum was used:

_____Version of the National Department of Transportation Curriculum was used for the level of training indicated above. The course included:

_____didactic hours_____lab hours

_____ clinical hours _____field internship hours

Did the training include? (Please check all boxes that apply)

☐ Mast	☐ AED	☐ Epinephrine	☐ IV Administration
☐ IV Maintenance	☐ EOA	☐ Combi-tube Airway	☐ PtL Airway
☐ Tracheal Intubation	☐ NTG	☐ Inhalers	☐ D50 Administration

I hereby verify that the above named individual attended the required hours and clinical rotations for successful completion of the program indicated above.

_____ _____
Print Verifying Individual's Name **Title**

_____ _____
Signature of Verifying Individual **Date**

Your cooperation is greatly appreciated. If you have questions, please contact the training section at (615) 741-4521. Please return to the address above.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
Division of Emergency Medical Services

Paramedic Comprehensive Practical Skills Evaluation

Student Name:_____

Students must show proficiency in all of the skills listed below either in competency and/or theory.

* denotes those that require competency

SKILL	COMPETENCY Initial and date	THEORY Initial and Date
MEDICATION AND FLUID ADMINISTRATION		
Routes of Administration		
1. Withdraw from a Vial*		
2. Oral Route*		
3. Sublingual Route*		
4. Subcutaneous Route*		
5. Intramuscular Route*		
6. Endotracheal Route*		
7. Intradermal Route		
8. Topical Route		
9. Gastric Tube Route		
10. Rectal Route		
11. Intranasal Route		
12. Peripheral IV Insertion*		
13. Intraosseous Infusion*		
14. External Jugular IV*		
15. IV Bolus*		
16. Piggy Back IV*		
17. Metered-Dose Inhaler*		
18. Hand-Held Nebulizer*		
BLOOD SAMPLE		
19. IV*		
20. Vacutainer*		
21. Needle and syringe*		
22. Glucometer*		
AIRWAY		
23. BLS Airway Obstruction Conscious Adult, Child and Infant*		
24. BLS Airway Obstruction Unconscious, Adult Child and Infant*		
25. CPR Adult, Child, and Infant*		
26. Mouth to Mask Adult, Child and Infant*		
27. Mouth to Mask to Stoma		
28. Pocket Mask*		
29. BVM Adult*		
30. BVM Pediatric*		
31. CPAP/BiPAP		
32. Auto Transport Vent		
33. Nasopharyngeal Airway*		
34. Oropharyngeal Airway*		
35. Orotracheal Intubation*		
36. Orotracheal Intubation /Spinal Trauma*		
37. Orotracheal Intubation/Pediatric*		
38. Nasotracheal Intubation*		

SKILL	COMPETENCY Initial and date	THEORY Initial and Date
39. Digital Intubation		
AIRWAY		
40. CO2 Detectors*		
41. Esophageal Detectors*		
42. LMA Insertion*		
43. Tracheal Suction*		
44. Nasogastric Decompression*		
45. Multi-Lumen Airway*		
46. RSI		
47. Translaryngeal Jet Ventilation*		
48. Surgical Cricothyrotomy		
49. Needle Chest Decompression*		
PATIENT ASSESSMENT		
50. Trauma*		
51. Medical*		
COMMUNICATIONS		
52. Radio Transmission*		
SPINAL TRAUMA		
53. Manual In Line Supine Immobilization*		
54. Log Roll Prone*		
55. Log Roll Supine*		
56. Clam Shell Device*		
57. Rapid Extrication*		
58. Long Spine Board Supine*		
ABDOMINAL TRAUMA		
59. PASG*		
MUSCULOSKELITAL TRAUMA		
60. Traction Splint*		
61. Joint Immobilization*		
62. Long Bone Immobilization*		
CARDIAC		
63. Vagal Manuvers*		
64. 12 Lead Therapy		
65. Defibrillation*		
66. Synchronized Cardioversion*		
67. Transcutaneous Pacing*		
RHYTHM RECOGNITION		
68. NSR*		
69. Atrial Fibrillation*		
70. Atrial Flutter*		
71. Atrial Tachycardia*		
72. Sinus Bradycardia*		
73. Sinus Tachycardia*		
74. PSVT*		
75. PAC*		
76. Junctional*		
77. Accelerated Junctional*		
78. PJC*		
79. 1st Degree Block*		
80. 2nd Degree Blocks*		
81. 3rd Degree Block*		
82. Idioventraicular*		
83. Ventricular Fibrillation*		

SKILL	COMPETENCY Initial and date	THEORY Initial and Date
84. Ventricular Tachycardia*		
85. PVC*		
86. Torsade de Pointes*		
87. PEA*		
88. Asystole*		
NEUROLOGICAL		
89. Neurological Assessment*		
90. Acute Ischemic Stroke Assessment*		
BEHAVIORAL		
91. Patient Restraints		
OBSTETRICS		
92. Normal Vaginal Delivery (Full Term)*		
93. Supine Hypotensive		
94. Pre-Eclampsia		
95. Eclampsia		
96. Breech		
97. Prolapsed Cord		
98. Limb Presentation		
99. Multiple Births		
100. Premature Infant*		
NEONATALOGY		
101. Umbilical Vein Cannulation		
HOME HEALTH CARE		
102. Evaluation of Peripheral Vascular Access*		
103. Clearing Obstructed Peripheral Venous Access*		
104. Draw Blood from Central Line		
105. Implanted venous catheters		
106. PIC Cannulations		
107. Infusion Pumps		
108. PEG Tubes		
OTHER SKILLS		
109. Male Catherization*		
110. Female Catherization*		
111. Nasogastric Tube *		

I verify that I have completed all the above skills through theory and have obtained competency in those indicated with an asterisk.

Student Printed Name _____ Student Signature _____ Date _____

I confirm that the above named student has completed all the above skills through theory and has obtained competency in those indicated with an asterisk.

Paramedic Program Director (Printed or Typed) _____ Paramedic Program Director Signature _____ Date _____

Medical Director (Printed or Typed) _____ Medical Director Signature _____ Date _____

STATE OFTENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
Accredited Educational Institutions
for
Emergency Medical Technician And Paramedic Training

NORTHEAST TENNESSEE REGION

Northeast State Technical Community College*
P.O. Box 246
2425 Hwy. 75
Blountville, TN 37617-0246
Phone: 423-323-3191
Fax : 423-323-0213
Paramedic, EMT-IV, First Responder

EAST TENNESSEE REGION

Roane State Community College*
Health Science Center
132 Hayfield Road
Knoxville, TN 37922
Phone: 865-539-6904 or 1-539-6905
Fax : 865-539-6907
Paramedic, EMT-IV, First Responder

Walters State Community College *
Emergency Medical Technology
500 S. Davey Crockett Pky.
Morristown, TN 37813-6899
Phone: 423-585-2600
Fax: 423-585-6853
Paramedic, EMT-IV, First Responder

SOUTHEAST TENNESSEE REGION

Chattanooga State Technical Community College*
EMS Management Program
407 Chestnut Street, Level B
Chattanooga, TN 37402-4905
Phone: 423-634-7707
Fax: 423-634-7706
Paramedic, EMT-IV

Cleveland State Community College
Health Science Department
P.O. Box 3570
Cleveland, TN 37320-3570
Phone: 423-478-6228
Fax: 423-478-6255
EMT-IV

SOUTHEAST TENNESSEE REGION

Chattanooga Fire Department **
3200 Amnicola Hwy
Chattanooga, TN 37406
Phone: 423-697-1453
Fax: 423-697-1420
EMT-IV

UPPER CUMBERLAND TENNESSEE REGION

Tennessee Technological University
Division of Extended Services
P.O. Box 5073
Cookeville, TN 38505
Phone: 931-372-3394
Fax: 931-372-3499
Paramedic, EMT-IV

Livingston Technology Center
P.O. Box 219
Livingston, TN 38570
Phone:
Fax:
EMT-IV

MID-CUMBERLAND TENNESSEE REGION

Middle Tennessee State University
Office of Continuing Studies
Murfreesboro, TN 37132
Phone: 615-898-2462
Fax: 615-898-3593
EMT-IV

Volunteer State Community College *
Allied Health Division
EMS Education
1480 Nashville Pike
Gallatin, TN 37066
Phone: 615-741-3215, 615-452-8600 Ext. 3346 or 3347
Fax: 615-230-3344
Paramedic, EMT-IV, First Responder

MID-CUMBERLAND TENNESSEE REGION

Nashville Metro Fire Department **
Training Academy **
2601 Buena Vista Pk.
Nashville, TN 37218
Phone: 615-862-5390
Fax: 615-862-5397
EMT-IV

SOUTH CENTRAL TENNESSEE REGION

Columbia State Community College*
P.O. Box 1315
Hampshire Pike, Highway 99 West
Columbia, TN 38402-1315
Phone: 931-540-2784
Fax: 931-540-2795
EMT-IV, Paramedic

Motlow State Community College
Lynchburg Highway
Tullahoma, TN 37388
Phone: 931-393-1750
Fax: 931-393-1761
EMT-IV

University of the South
S.P.O. 1254
Sewanee, TN 37375
Phone: 931-598-1000
Fax: 931-598-1145
EMT-IV

RURAL WEST TENNESSEE REGION

Jackson State Community College *
Emergency Medical Technology
2046 N. Parkway
Jackson, TN 38301
Phone: 901-425-2612
Fax: 901-425-2647
Paramedic, EMT-IV

MEMPHIS-DELTA TENNESSEE REGION

Dyersburg State Community College
1510 Lake Road
Dyersburg, TN 38024
Phone: 901-286-3390
Fax: 901-286-3333
EMT-IV

Southwest State Community College *
Emergency Medical Technology Department
Division of Allied Health
P.O. Box 40568
Memphis, TN 38174-0568
Phone: 901-544-5412
Fax: 901-544-5391
Paramedic, EMT-IV

Memphis Fire Department
Training Academy **
2668 Avery
Memphis, TN 38112
Phone: 901-320-5397
EMT-IV

* Indicates National Accreditation
** Not opened to general public

TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
CORDELL HULL BUILDING, FIRST FLOOR
425 FIFTH AVENUE NORTH
NASHVILLE, TN 37247-0701

TELEPHONE: 615-741-2584
FAX# 615-741-4217

REGIONAL EMS OFFICES

Region 1

Department of Health
Division of Emergency Medical Service
Northeast Tennessee Regional Office
1223 S. W. Avenue Ext.
Johnson City, TN 37604
Phone: 423-979-3200 (111)
Fax: 423-979-3267

Region 2

Department of Health
Division of Emergency Medical Services
Office of Health Licensure and Regulations
Lakeshore Park, Building # 1
5904 Lyons View Pike
Knoxville, TN 37919
Phone: 865-588-2469
Fax: 865-594-5739

Region 3

Department of Health
Division of Emergency Medical Services
Southeast Regional Health Office
Suite 450, Room 3
540 McCallie Avenue
Chattanooga, TN 37402
Phone: 423-634-3124
Fax: 423-634-3139

Region 4

Department of Health
Division of Emergency Medical Services
Upper Cumberland Regional Office
200 West 10th Street
Cookeville, TN 38501-6076
Phone: 931-528-7531
Fax: 931-520-0413

Region 5

Department of Health
Division of Emergency Medical Services
Mid-Cumberland Regional Health Office
710 Hart Lane
Nashville, TN 37247-0801
Phone: 615-650-7010
Fax: 615-262-6139

Region 6

Department of Health
Division of Emergency Medical Services
South Central Regional Health Office
1216 Trotwood Avenue
Columbia, TN 38401-4899
Phone: 931-380-2532 ext. 121
Fax: 931-380-3364

Region 7

Department of Health
Division of Emergency Medical Services
Rural West TN Regional Health Office
781-B Airways Boulevard
Jackson, TN 38301
Phone: 731-421-5116
Fax: 731-423-6572

Region 8

Department of Health
Division of Emergency Medical Services
Memphis Regional Health Office
814 Jefferson Avenue
Memphis, TN 38105
Phone: 901-543-7049
Fax: 901-543-7710